Beginning Billing Workshop
CMS 1500

Health First Colorado
(Colorado's Medicaid Program)

COLORADO
Department of Health Care Policy & Financing

Program Overview

CMS.gov
Centers for Medicare & Medicaid Services

COLORADO
Department of Health Care Policy & Financing

DXC.technology

Health First Colorado/CHP+ Medical Providers

Training Objectives

- Navigate the Department's website
- Billing Pre-Requisites
  - Provider Enrollment
    - National Provider Identifier (NPI)
    - Health First Colorado Enrollment
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are within timely filing guidelines
  - How to bill when other payers are involved

CMS 1500

Who completes the CMS 1500?

HCBS/Waiver providers

Vision providers

Physicians/Other Practitioners

Supply providers

Surgeons

Transportation providers

Department Website

1

www.colorado.gov/hcpf

https://www.colorado.gov/hcpf

Colorado The Official Web Portal

Translate

HCPF | COLORADO
Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers | For Our Stak... | Ab...

2

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore Benefits

Apply Now

Find Doctors

Get Help

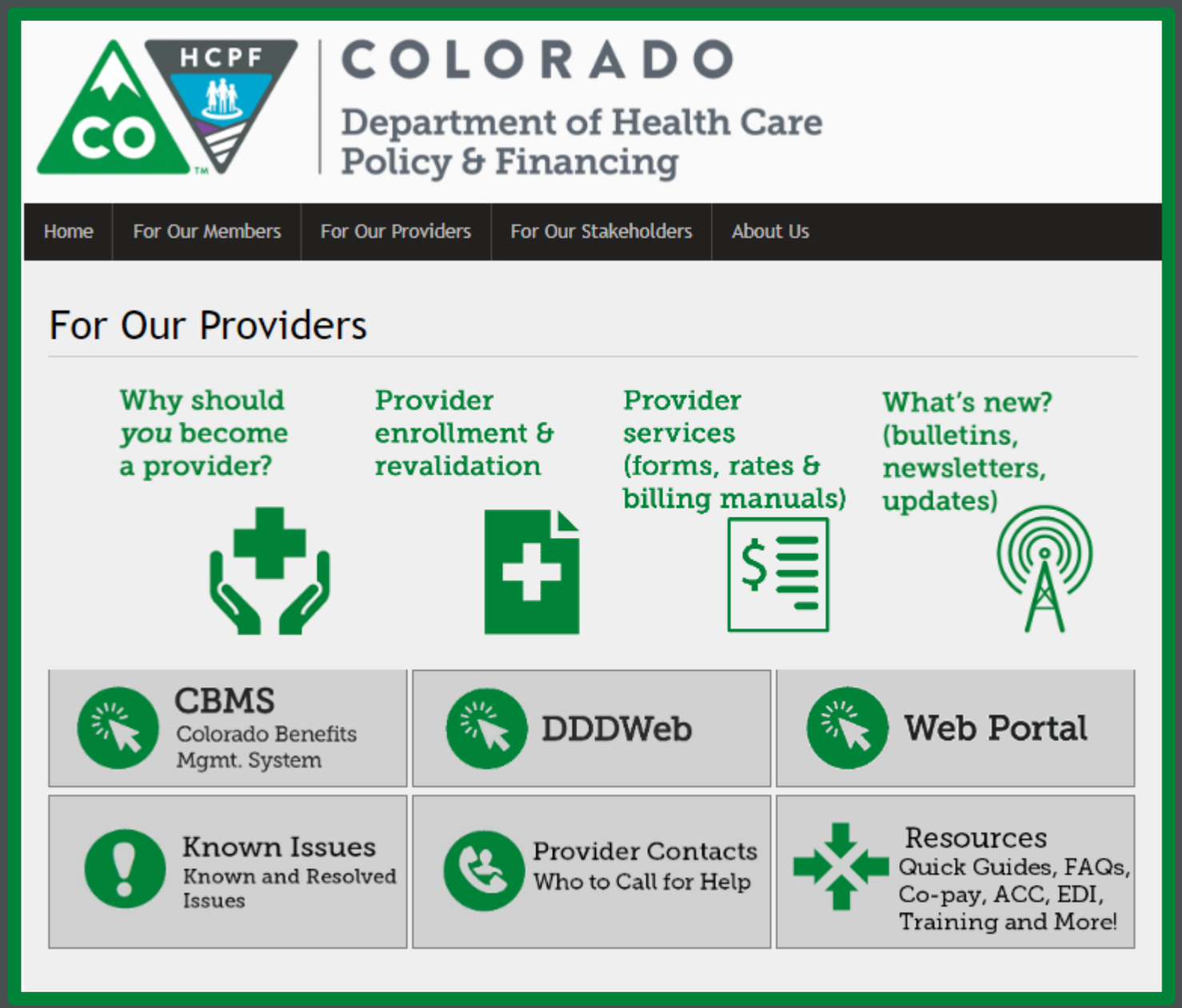
Feeling Sick?
For medical advice, call the Nurse Line:
800-283-3221

Get Covered. Stay Healthy.
colorado.gov/health

Provider Home Page

Find what you need here

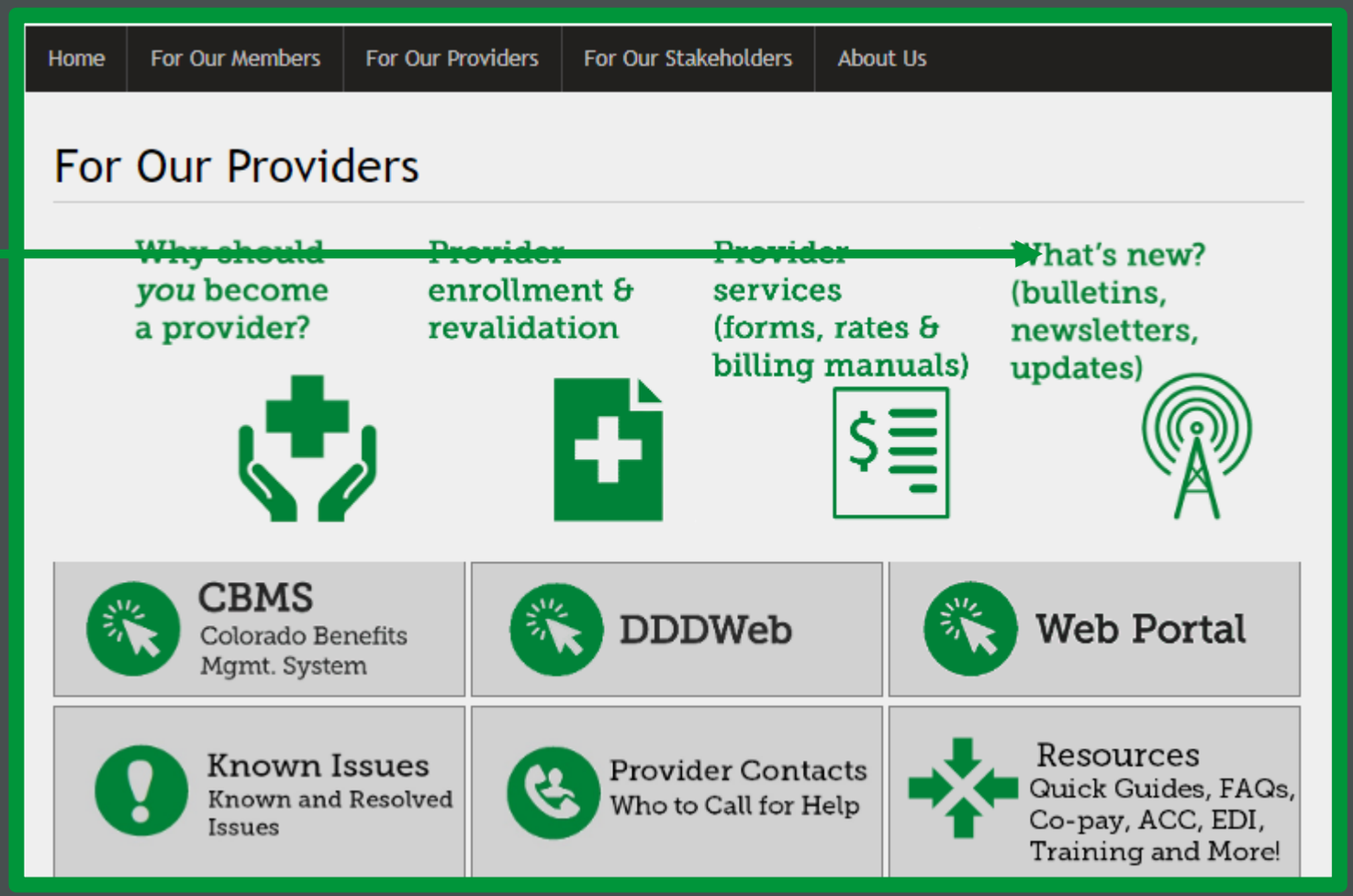
Contains important information regarding Health First Colorado (Colorado's Medicaid Program) & other topics of interest to providers and billing professionals



What's New, Bulletins, Newsletters

Find what you need here

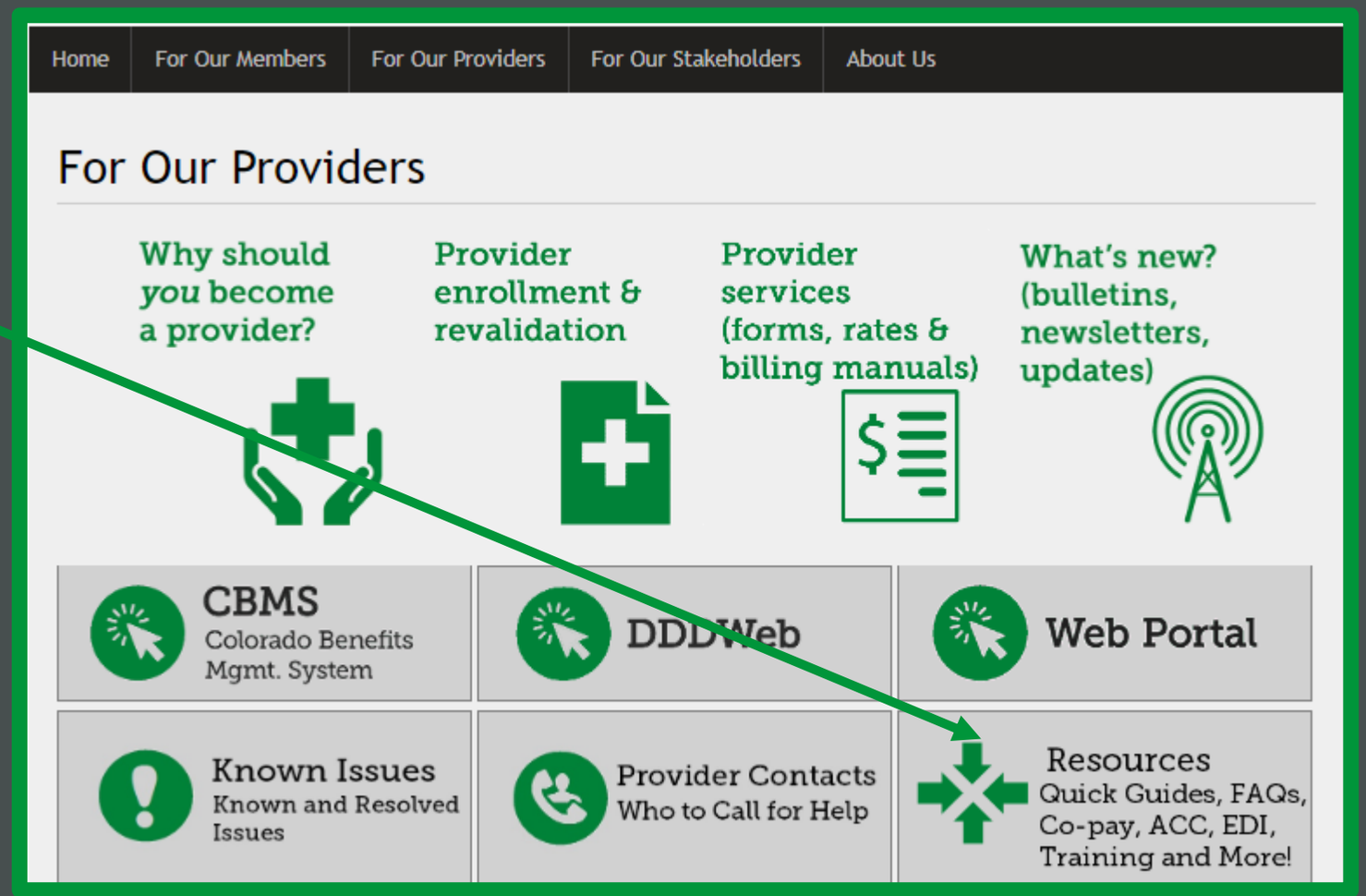
Contains our weekly newsletter and our bulletins



Provider Resources

Find what you need here

Quick Guides, FAQs, EDI information, training, and more!



Provider Resources (cont.)

National Provider Identifier (NPI)

- A National Provider Identifier (NPI) is a unique 10-digit identification number issued to U.S. health care providers by CMS
- Non-medical providers such as home and community based services do not require an NPI
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions.
- The Colorado Interchange claims system will use the NPI to find the unique Health First Colorado Provider ID.
- NPIs are permanent for individual providers regardless of rendering provider location or affiliation. Individuals should only have one NPI and one Health First Colorado ID.

National Provider Identifier

- How to Obtain an NPI & Learn Additional Information:
  - CMS web page
    - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf
  - National Plan and Provider Enumeration System (NPPES)-
    - https://nppes.cms.hhs.gov
    - 1-800-456-3203
    - 1-800-692-2326 TTY

Provider Enrollment

Question:

What does **Provider** Enrollment do?

Answer:

Enrolls **providers** into Health First Colorado, *not* members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Health First Colorado members

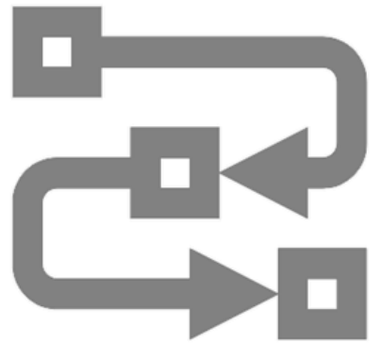
- Additional information for provider enrollment and revalidation is located at the Provider Resources website

Verifying Eligibility

- Always save copies of eligibility verifications
- Keep member's eligibility information in member's file for auditing purposes
- Member's eligibility must be checked on each date of service
- Ways to verify eligibility:

Provider Web Portal

IVR
1-844-235-2387



Batch X12 270

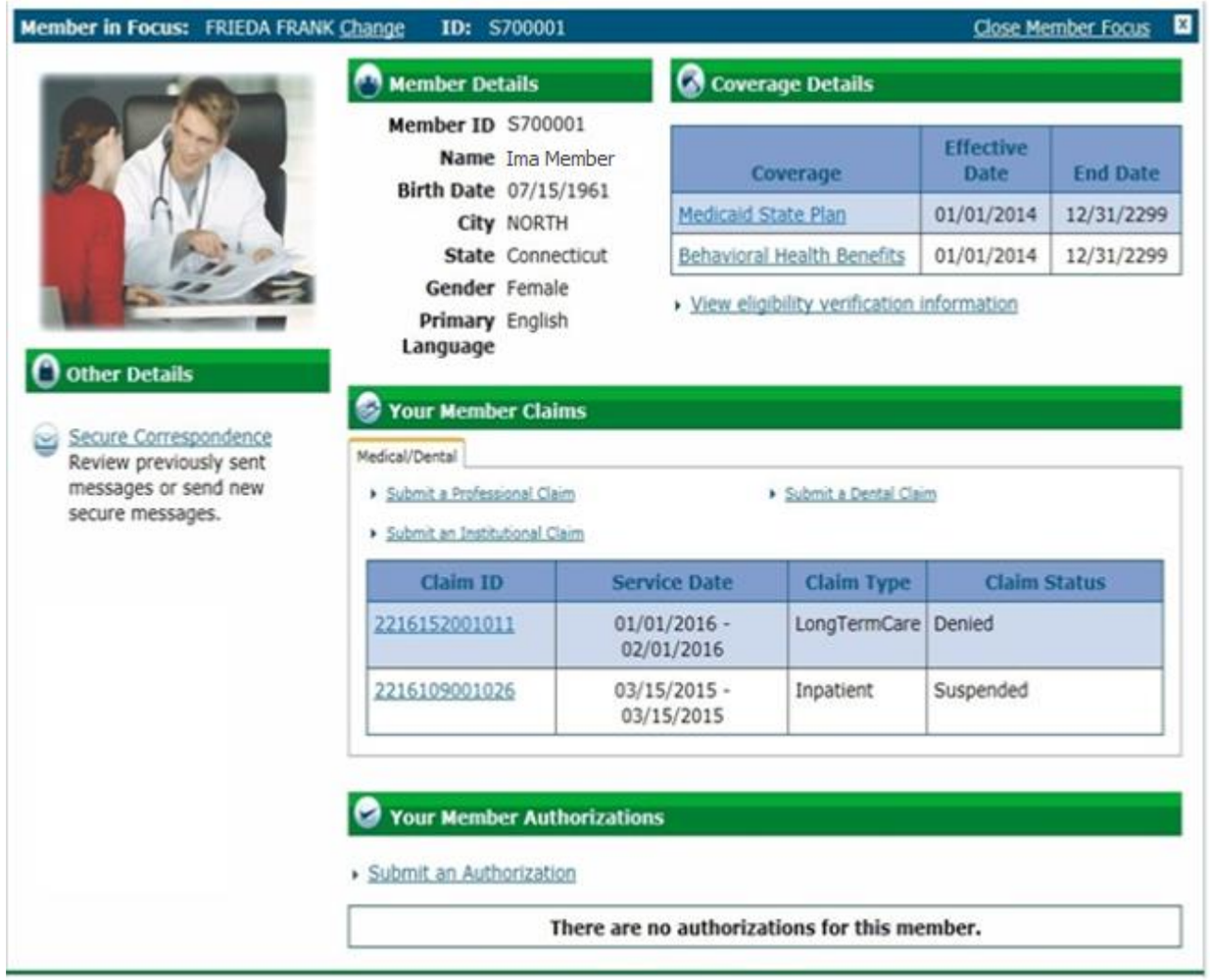
From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

Eligibility Response Information

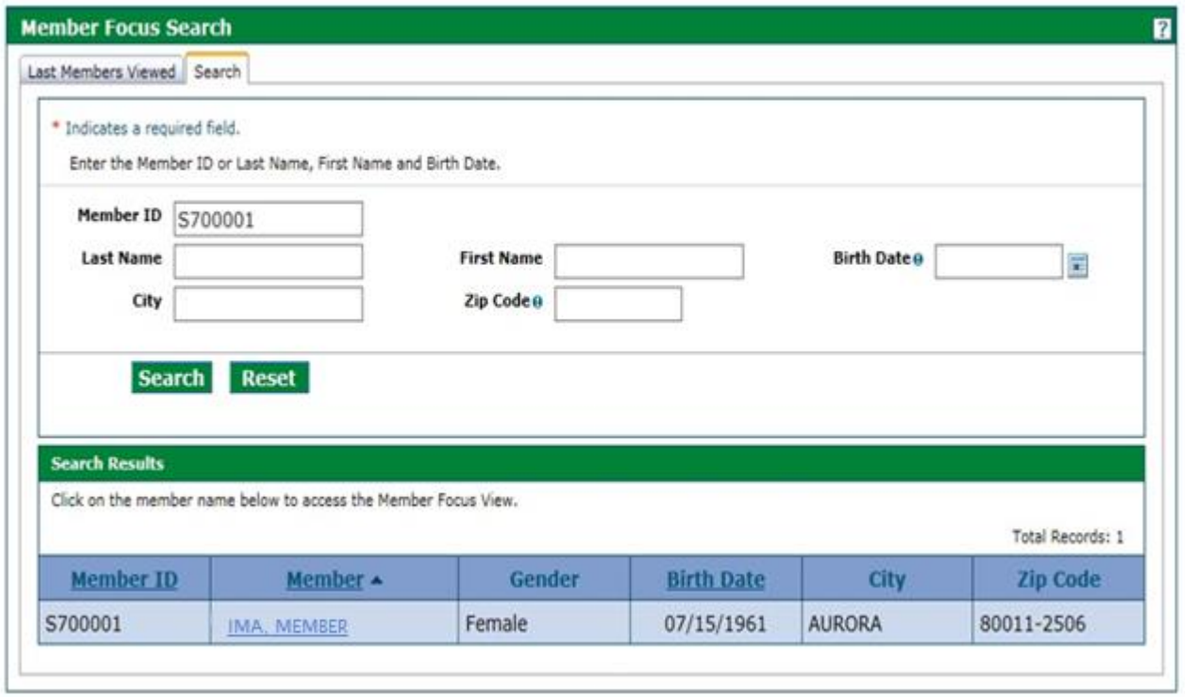
- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Managed Care Plan
- Medicare
- Special Eligibility
- Regional Accountable Entity (RAE)
- Alternative Benefit Plan (ABP) – members must show Title 19 (XIX) in addition to ABP

Viewing Member Information on the Provider Web Portal

Verification called “CAPTCHA” to ensure provider is not a robot will be required first. On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.



Search tab -



This search will display the Member in Focus page which provides Member Details, Coverage Details, Member Claims, and Member Authorizations.

Health First Colorado Identification Cards

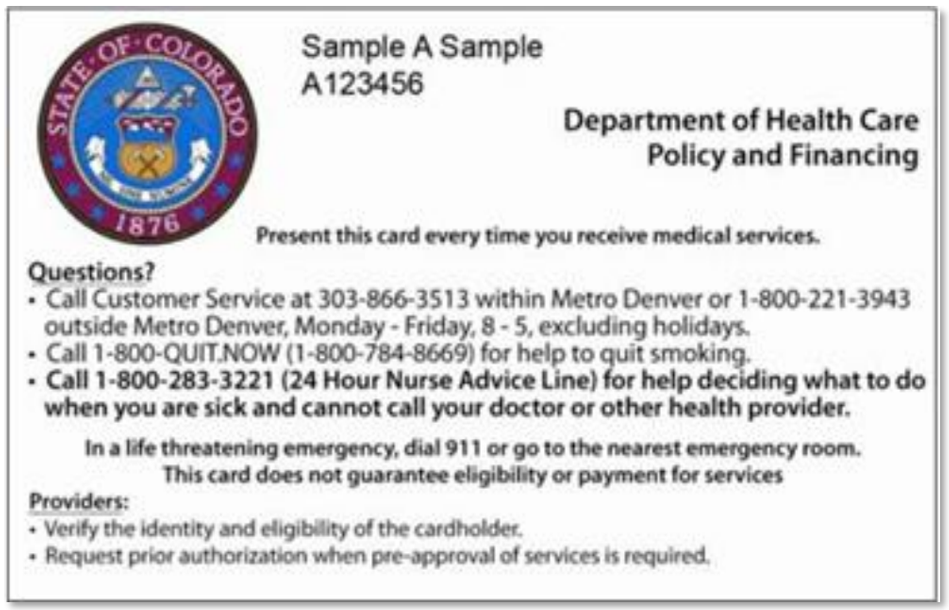
- Older branded cards are valid
- Identification Card does not guarantee eligibility


Health First COLORADO
Colorado's Medicaid Program

Member name: FirstName LastName
Member ID #: ########

- Talk to a nurse anytime at 1-800-283-3221. Dial 911 or go to the ER in a life threatening emergency.
- View coverage and co-payment info or find a provider:
  - Colorado.gov/HCPF
  - PEAK*Health* mobile app
  - Call 1-800-221-3943 or State Replay 711, M-F, 7:30am-5:15pm
- Keep your coverage and info current:
  - Colorado.gov/PEAK
  - PEAK*Health* mobile app
- Bring a photo ID when you go to your provider or pharmacy.

Providers: This card does not guarantee eligibility or payment for services. You must verify identity and eligibility before providing services.


Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Eligibility Types

- Most members = Regular Health First Colorado benefits
- Some members = different eligibility type
  - Old Age Pension, state-only
  - Non-Citizens
  - Presumptive Eligibility
  - Managed Care
- Some members = additional benefits
  - Medicare
  - Third Party Insurance (Commercial Insurance)

Eligibility Types

Old Age Pension – State only

- Members are not eligible for regular benefits due to income
- Some Health First Colorado payments are reduced payment to the providers since the program only gets state funds and no federal match.
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Home Health
  - Home and Community Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services

Eligibility Types

Non-Citizens

- Eligibility type only covers emergency services.
- Claim must have emergency checked “Yes” for electronic claims or indicated in box 24C on the paper 1500 form.
- Emergency services must be certified in writing by provider and kept on file, but do not need to be submitted with the claim

What Defines an “Emergency”?

- The provider determines whether or not the service is considered an emergency and marks the claim appropriately.
- An emergency is defined as a sudden, urgent, usually unexpected occurrence or occasion requiring immediate action, including acute symptoms of sufficient severity & severe pain in which the absence of medical attention might result in:
  - Placing health in serious jeopardy
  - Serious impairment to bodily functions
  - Dysfunction of any bodily organ or part

Active labor and delivery is an example of an emergency.

Eligibility Types

Presumptive Eligibility

- Temporary coverage of Health First Colorado or CHP+ services until eligibility is determined

- Health First Colorado Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
    - Covers labor and delivery, but does not cover any OTHER inpatient services
  - Children ages 18 and under
    - Covers all Health First Colorado covered services

- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

Eligibility Types

Presumptive Eligibility (cont.)

- Health First Colorado Presumptive Eligibility claims
  - ➢ Submit to the Fiscal Agent (DXC)
- CHP+ Presumptive Eligibility and claims
  - ➢ Submit to Colorado Access or Denver Health

Managed Care

Managed Care Organizations (MCOs)

- Rocky Mountain Health Plans
- Denver Health

Program of All-Inclusive Care for the Elderly (PACE)

Regional Accountable Entity (RAE)

Managed Care Options

Managed Care

Managed Care Organization (MCO)

- Some services are not included in the managed care contract. Those fee for service claims can be billed directly to fiscal agent.
  - Examples include:
    - Pediatric Behavioral Therapies
    - Auditory Services for children
    - HCBS Services including home modification, electronic monitoring, and non-medical transportation.

Managed Care

Regional Accountable Entity (RAE)

- RAEs pay for behavioral health claims, however they do not pay for pediatric behavioral therapy.
- The first six (6) behavioral health visits are billed directly to DXC by the primary care provider, and not to the RAE
- Each area managed by a specific RAE
  - Contact RAE in your area to become a Behavioral Health Program Provider or to enroll as a Primary Care Provider
  - https://www.colorado.gov/hcpf/accphase2

Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Members only pay Health First Colorado co-pay
- Health First Colorado uses lower of pricing logic to pay claims –either coinsurance and deductible **or** difference between Medicare paid amount and Health First Colorado allowed amount.
- Covers any service covered by Medicare.
  - QMB Medicaid (QMB+)- members also receive Health First Colorado benefits (Title XIX)
  - QMB Only- members do not receive Health First Colorado benefits

    Eligibility will only show QMB. Will not show Title XIX coverage.

Medicare

Medicare-Health First Colorado Enrollees

- Eligible for both Medicare & Health First Colorado
- Health First Colorado is always payer of last resort
  - Bill Medicare first for Medicare-Health First Colorado Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for seven (7) years
  - Medicare EOB does not need to be attached to every claim submission, unless it is on paper. Providers should be billing electronically.

Third Party Liability (Commercial Insurance)

- Health First Colorado is always payer of last resort
- Indicate TPL EOB date on each claim

EOB does not need to be attached to every claim submission

- Provider cannot:
  - Bill member difference
  - Bill member for co-pay/deductible assessed by the TPL

Third Party Liability (Commercial Insurance)

- Health First Colorado (Colorado's Medicaid Program) pays the difference between TPL payment and Program Allowable
  - Example:
    - Charge = $500
    - Program allowable = **$400**
    - TPL payment = **$300**
    - Program allowable – TPL payment = **Reimbursement**

$400.00
- $300.00
= $100.00

Co-Pay

- **Auto-deducted during claims processing**
  - Do not deduct from charges billed on claim
- **A provider may not deny services to an individual when such members are unable to immediately pay the co-pay amount. However, the member remains liable for the co-pay at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)**
- **Youth from birth to 18 years old are considered children**
- **Services that do not require co-pay:**
  - Dental
  - Home Health
  - HCBS waiver services
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services (mental health and substance use disorder)

Co-Pay

- The co-pay maximum is 5% of the household monthly income.

- The head of household will receive a letter showing the household has reached the monthly limit.

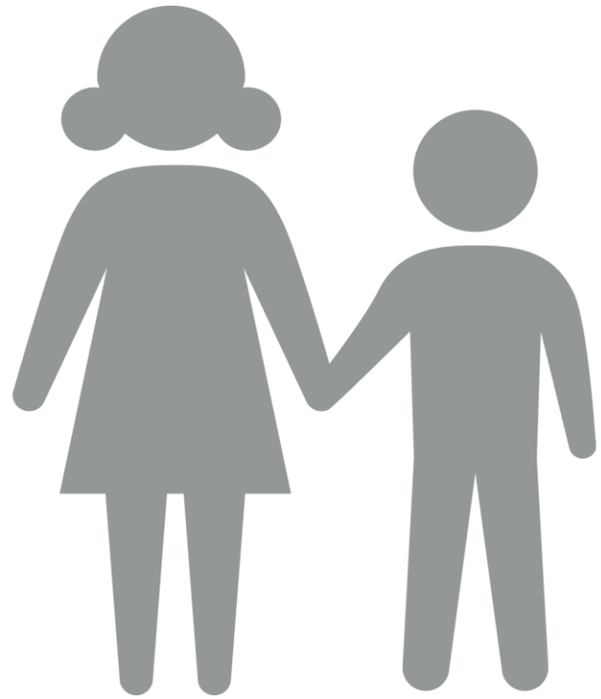
- Members who track their own co-pay amounts may claim they have reached their maximum for the month before the Provider Web Portal reflects this information. If Health First Colorado members state they have met their monthly co-pay maximum, but the Web Portal indicates they owe a co-pay amount at the time of their visit, it may be because the health care claims from other providers have not been submitted yet.

- Providers are encouraged to submit claims as soon as possible to ensure a co-pay does not need to be refunded to the member.

Co-Pay Exempt Members

Nursing Facility Residents

Pregnant Women



Children and Former Foster Care Eligible*

*former foster care eligible still has a pharmacy co-pay

From the Noun Project:
"Nursing-Home" by Iconathon
"Children" by OCHA Visual Information Unit
"Maternity-Cycle" by HCPF

Specialty Co-pay

Practitioner, Optometrist, Speech Therapy, RHC / FQHC	$2.00
DME / Supply	$1.00 per date of service
Outpatient	$4.00
Inpatient	$10.00 per covered day or 50% of average allowable daily rate - whichever is less
State Plan Psych Services	.50 per unit of service, 1 unit = 15 minutes

Billing Overview

Record Retention

Prior Authorization Requests (PARs)

Claim submission

Timely filing

Extensions for timely filing

Record Retention

- Providers must:
  - Maintain records for at least seven (7) years
  - Longer if required by:
    - Specific contract between provider & Health First Colorado
  - Furnish information upon request about payments claimed for Health First Colorado services

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Electronic record keeping is also allowed and encouraged

PARs Reviewed by eQ Health (the ColoradoPAR program)

- The ColoradoPAR Program reviews PARs for the following categories or services and supplies:
  - Diagnostic imaging
  - Durable medical equipment
  - Inpatient admissions
  - Medical services (including transplant, back and bariatric surgery)
  - Physical, occupational, and speech therapy
  - Pediatric behavioral therapy
  - Pediatric long-term home health
- Adult long-term home health PARs do not go through eQ Health, but through the case management agency.

Electronic PAR Information

- ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Regional Accountable Entities.
- All PARs for members age 20 and under are reviewed according to EPSDT guidelines. Even if it's not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child.
- PARs/revisions processed by the ColoradoPAR Program must be submitted via eQSuite®
- The ColoradoPAR Program will process PARs submitted by paper only if provider fills out the eQSuite® Exception Request Form

Website:	Phone:
www.ColoradoPAR.com	Phone: 1.888.801.9355 FAX: 1.866.940.4288

PAR Letters/Inquiries

- Final PAR determination letters
  - Mailed to members
  - Posted to Department's prior authorization vendor's web portal, eQSuite®
- Letter inquiries should be directed to ColoradoPAR
- Providers can review PARs via the eQSuite® portal

Home & Community Based Services (HCBS) Waiver PARs

Contact your community center board (CCB) or single entry point representative (SEP) to submit prior authorization.

Submitting Claims

- Methods to submit:
  - Electronically through DXC's Web Portal (free of charge)
    - Interactive, one claim at a time
  - Electronically using Batch Vendor or Clearinghouse
  - Paper only when:
    - Pre-approved (consistently submits less than five (5) per month)

Providers Not Enrolled with EDI

Providers do not need to obtain a trading partner ID to access the web portal.

Only a submitter who sends batch transactions or receives batch reports needs to enroll in EDI for a trading partner ID.

Colorado.gov/hcpf/EDI-Support

Crossover Claims

Automatic Medicare Crossover Process:

- **Crossovers may not be adjudicated by Health First Colorado if:**
  - NPI used on Medicare Claim does not match NPI enrollment with DXC
  - Member is a retired railroad employee
  - Member has incorrect or missing Medicare information on file

Payment Processing Schedule

Mon. | Tue. | Wed. | Thur. | Fri. | Sat.

Providers bill claims

Weekly claim submission cutoff

Mon. | Tue. | Wed. | Thur. | Fri. | Sat.

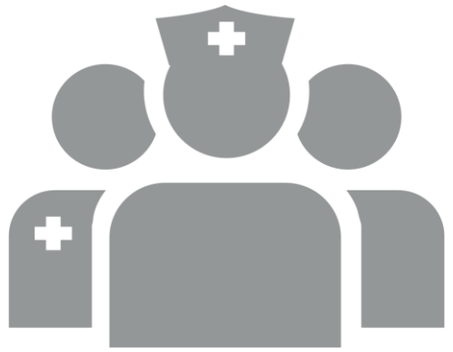
RAs and 835s posted to the Web Portal

EFT payments deposited to provider accounts

Rendering Versus Billing

Rendering Provider (Individual within a group)

Individual that provides services to a Health First Colorado member



Billing Provider

Entity being reimbursed for service

From the Noun Project:
"Medical-Team" icon created by Pieter J. Smits
"Hospital" icon created by Carlotta Zampini

Timely Filing

- 365 days from Date of Service (DOS)
  - Determined by date of receipt
  - Certified mail is not proof of timely filing
  - PARs are not proof of timely filing
  - Contacting the fiscal agent or waiting for fiscal agent response to a verbal inquiry is not proof of timely

Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.

Timely Filing

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community Based Services	From the “through” date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Equipment rental - The service date must be the last day of the rental period	From the date of service

Timely Filing Extensions

- Extensions may be allowed when:
  - Medicare has yet to pay/deny
  - Backdated eligibility
    - Load letter
  - Provider Enrollment
    - Backdated Enrollment

Timely Filing Extensions

Rebilled Claims

- 60 days from date on:
  - Remittance Advice (RA) or 835
    - Use last Internal Control Number (ICN). Do not attach copy of RA with claim.
  - Returned Claim
    - Date stamped by the fiscal agent
- Keep supporting documentation

Timely Filing Extensions

Primary Payors

- **Commercial Insurance/Third Party Liability (TPL)**
  - Can not pay if over 365 days from DOS per federal statute
  - All claims which include commercial insurance (third-party liability) information that are received more than 365 days from the date of service must be denied per state and federal regulation (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02A). The provider is responsible for pursuing available third-party resources in a timely manner.
- **Medicare/Health First Colorado Enrollees**
  - Additional 120 days from Medicare EOB date

Timely Filing Extensions

Delayed Notification/Backdated Eligibility

Delayed Notification

- Providers are responsible for determining eligibility within 365 days, even if the member does not notify them of Health First Colorado eligibility. No further extensions are given for delayed notification of eligibility.

Load Letters

- 60 days from load letter

➢ Used when county backdates eligibility farther than 365 days

- Bill electronically

➢ Submit with copy of load letter via Web Portal

Timely Filing Extensions

Provider Enrollment

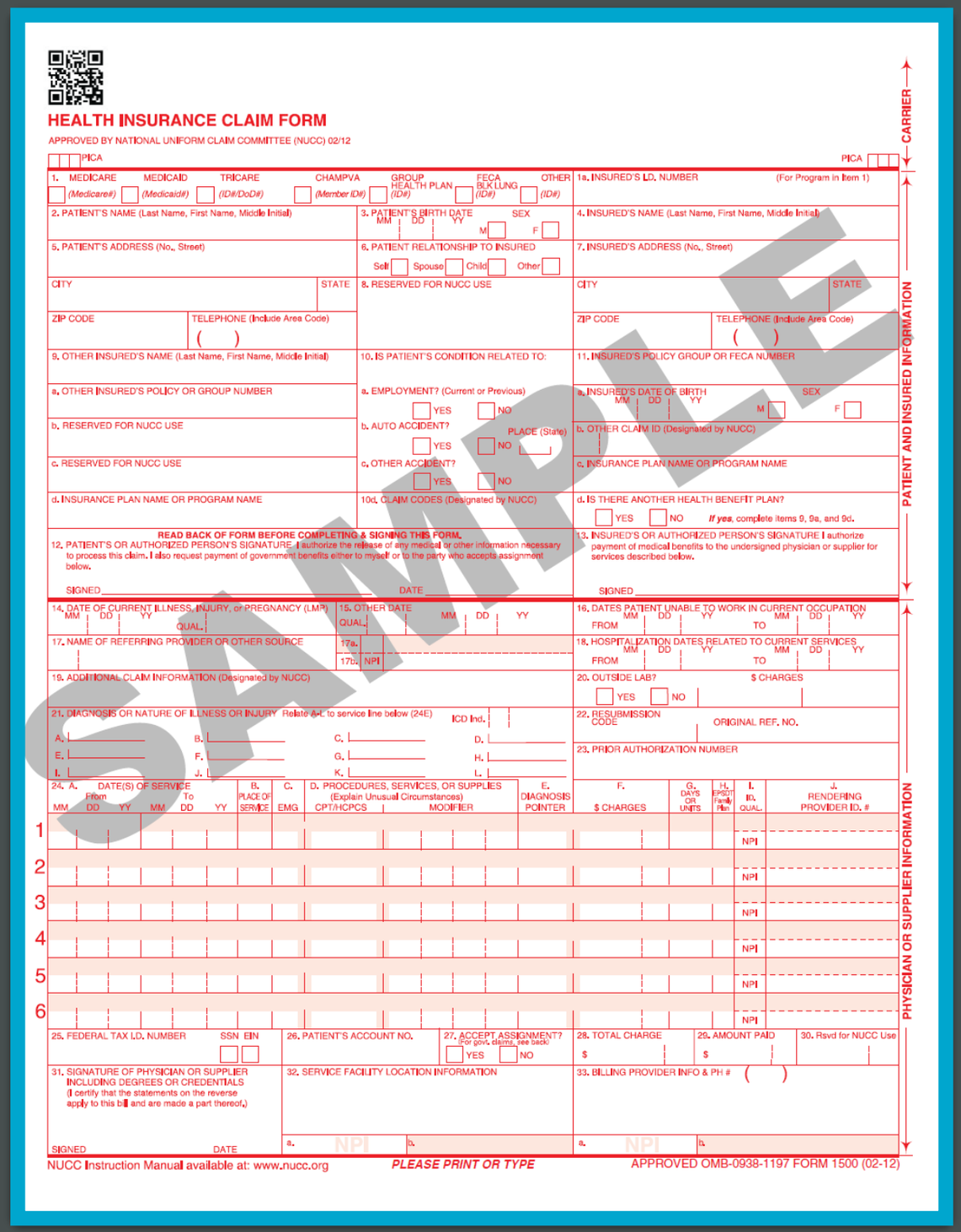
- 365 days from backdate approval

Providers do not need to submit claims while waiting for enrollment to be approved.

CMS 1500

Where can a Colorado Medical Assistance provider get the CMS 1500?

Information available on
https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)
CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
SAMPLE

Internal Control Number

Region
Two digits indicate the region. The region indicates how Health First Colorado received the claim.

Batch Number
Three digits indicate the batch range assigned to the claim. This is used internally by Health First Colorado.

RR

YY

JJJ

BBB

SSS

Year of Receipt
Two digits indicate the year Health First Colorado received the claim.

Julian Date of Receipt
Three digits indicate the day of the year that the claim was received.

Sequence Number
Three digits indicate the sequence number assigned within a batch range

For more information on Region Codes and Julian dates, visit our Quick Guides and Webinars page!

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without a reference to a previous ICN
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid
Bill Medicare or Other Insurance	Health First Colorado is always the "Payer of Last Resort" - Provider should bill all other appropriate carriers first. Primary information must be reported on the claim form.

Common Denial Reasons

PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total

Claims Process - Common Terms

Denied

Claim processed & denied by claims processing system. Some denied claims may be resubmitted for payment after corrections have been made. Denied claims may not be adjusted but may be resubmitted.

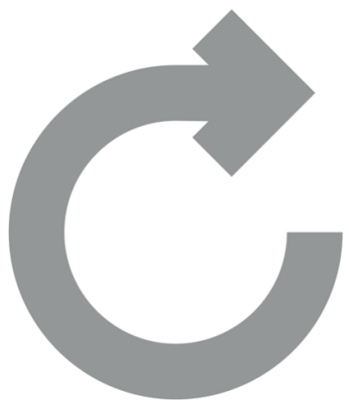
Paid

Claim processed & paid by claims processing system. Claims paid at zero due to lower of pricing are still considered paid.

Claims Process - Common Terms

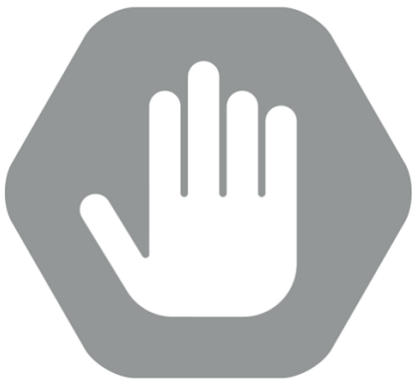
Adjustment

Correcting paid claims that are still within timely filing



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication

Void

“Cancelling” a “paid” claim

From the Noun Project:
“Delete” by Ludwig Schubert
“Stop” by Chris Robinson
“Check-Mark” by Muneer A.Safiah
“Money” by Nathan Thomson

Claims - Adjustments

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

- Claim was denied
- Claim is suspended

Claims - Adjustment Methods

Web Portal or Batch

- Preferred method
- Easier to submit & track

Paper

- Use adjustment indicator

From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

Paper Claim Form: CMS 1500

REQUIRED FIELDS

CONDITIONAL FIELDS

OPTIONAL FIELDS

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): Y123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM DD YY: 04 21 1950 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 555 Dandelion View

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown

STATE: CO

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 11111

TELEPHONE (Include Area Code): (123) 222-3333

ZIP CODE

TELEPHONE

Field 11, 11a, 4 - **Conditional.** Complete if the member is covered by a **Medicare** health insurance policy.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO X

b. AUTO ACCIDENT? YES NO X PLACE (State)

c. OTHER ACCIDENT? YES NO X

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

Field 11d, 6, 9, 9a, 9d - **Conditional.** Complete if the member is covered by a **Third party liability/Commercial** insurance policy.

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 061518

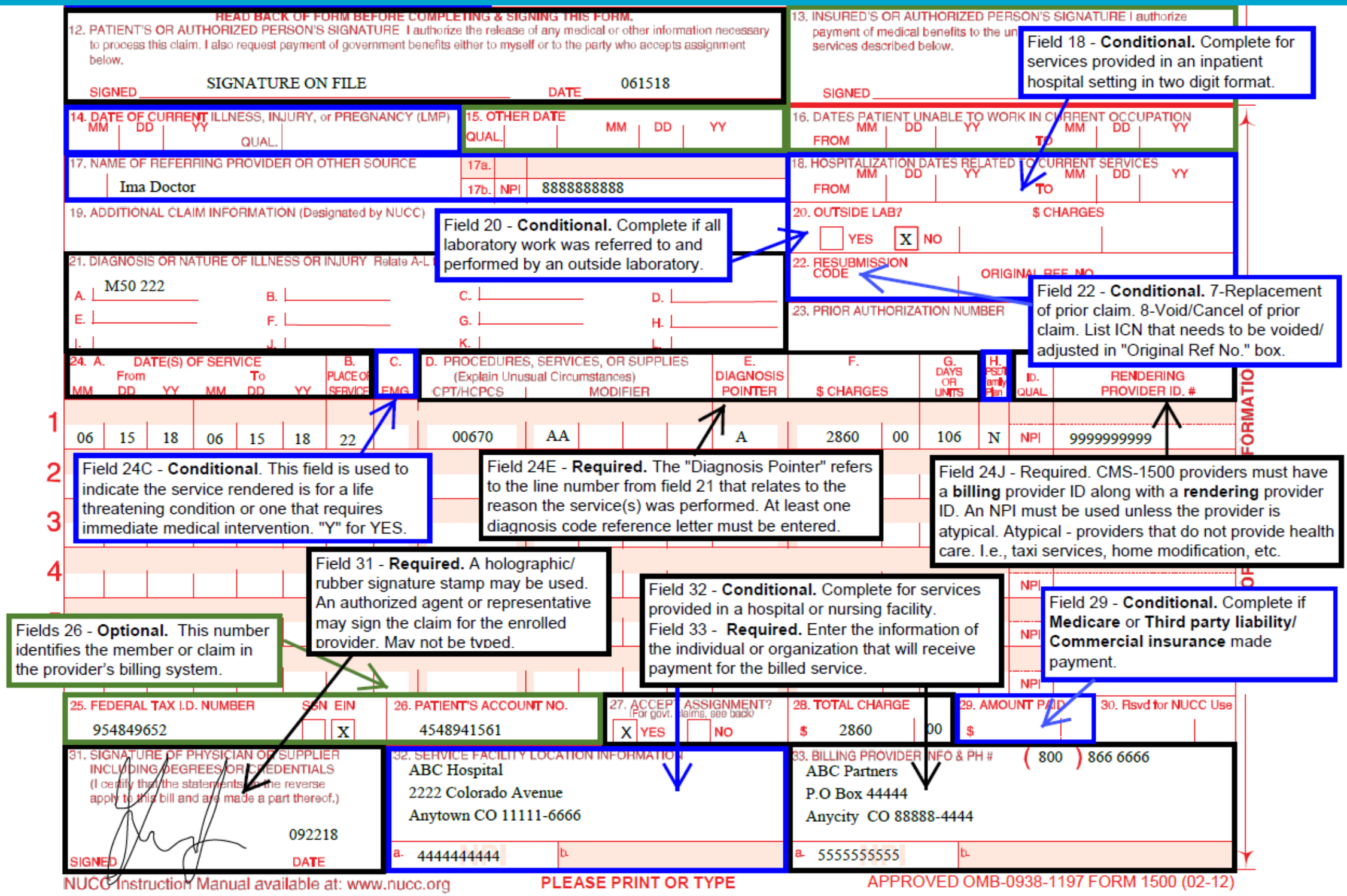
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

CARRIER

PATIENT AND INSURED INFOR

Paper Claim Form: CMS 1500



Provider Services Call Center
1-844-235-2387

Download the Call Center Queue Guide

7 a.m. - 5 p.m. MST Monday, Tuesday, & Thursday
10 a.m. - 5 p.m. MST Wednesday & Friday

The Provider Services Call Center will be utilizing the time between 7 a.m. and 10 a.m. on Wednesdays and Fridays to return calls to providers.

Thank you!